**BUREAU OF FACILITY STANDARDS – Department of Health and Welfare**
P.O. Box 83720, Boise, Idaho 83720-0036 (208) 334-6626

## APPLICATION FOR NURSING FACILITY LICENSE AND ANNUAL REPORT 2008

**NOTE**: Information provided on this form, such as facility name, address, and number of licensed beds, should match our **current** records **exactly**. If you need to make a change in these fields, please attach a separate letter outlining the change.

Nursing Facility Name: _____

Address: _____
Street Address and number or RFD

_____ , Idaho _____ _____
City Zip County

Telephone No.: (208) _____ Fax Number: (208) _____

Facility's E-Mail Address: _____

## I. REPORTING PERIOD.

The twelve-month period of **October 1, 2007**, through **September 30, 2008**, should be used for comparison and trend analysis purposes.

___ Yes, the facility was in operation for twelve full months as of **September 30, 2008**; the required reporting period was used.

___ No, the facility was not in operation for twelve full months as of **September 30, 2008**; an alternate reporting period was used.

Reporting Period Used: _____ No. of Days in Reporting Period: _____

## II. CLASSIFICATION – Ownership

**A.** Check the entity which has legal responsibility for operation of the facility.

_____ State or local government _____ Non-profit owner

_____ Federal government _____ For-profit owner

**B.** Are you:

_____ Freestanding _____ Hospital-based

## III. BEDS

### A. Current Bed Capacity

Total licensed beds _____ _____

Beds equipped for use _____ _____

### B. Bed Capacity Change

B.1. Has the licensed bed capacity changed during the reporting period?

___ No. ___ Yes. If yes, on what date (s) did the number change? _____

Previous licensed bed capacity _____ _____

B.2. Has the number of beds equipped for use changed during the reporting period?

___ No. ___ Yes. If yes, on what date (s) did the number change? _____

Previous number of beds equipped for use _____ _____

## IV. OCCUPANCY

Total number of inpatient days of care from **October 1, 2007**, through **September 30, 2008** _____ _____

## V. CNA TRAINING

Is Nurse Aide Training (NATCEP) being conducted in your facility by your staff or any other entity? _____ Yes ___ No ___

## VI. FISCAL YEAR

What is the facility's Fiscal Year Ending Date? _____ _____

## VII. FISCAL INTERMEDIARY

Who is the facility's current Fiscal Intermediary (Part A Medicare Contractor)?

_____

## VIII. CHANGES IN PHYSICAL SPACE USAGE

Are there other businesses and/or licensed/certified entities operating in any portion of the facility's physical space? _____ Yes ___ No ___

If yes, please list the business and/or licensed/certified entities.

_____

IF THERE ARE QUESTIONS ABOUT INFORMATION IN THIS REPORT, WHO SHOULD BE CONTACTED?

Name: _____

Title: _____

Telephone: _____

I CERTIFY THAT THE STATEMENTS MADE IN THIS REPORT ARE TRUE, COMPLETE, AND CORRECT TO THE BEST OF MY KNOWLEDGE

Signature of Administrator: _____

Date: _____

*Visit us on the web at http://www.facilitystandards.idaho.gov/*

# INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR NURSING FACILITY LICENSE AND ANNUAL REPORT - 2008

**Name of Facility**

This must match the facility's official licensed name exactly.

**Section I**

The reporting period of **October 1, 2007**, through **September 30, 2008**, shall be used for all skilled nursing facilities unless the facility began operations any time during the specified reporting period.

**Section II**

Part A: Self-explanatory

Part B: Hospital-based facilities are those managed by a hospital, not necessarily physically attached to the hospital.

**Section III**

Total licensed beds is the quantity appearing on the most recent license.

Beds equipped for use is the number currently available for patient use.

**Section IV**

Self-explanatory

**Section V**

Self-explanatory

**Section VI**

Self-explanatory

**Section VII**

Self-explanatory

**Section VIII**

Self-explanatory

If you have any questions concerning the completion of this form or clarification on definitions, please call Loretta Todd, R.N., or Lorene Kayser, L.S.W., Q.M.R.P., Long Term Care Supervisors at (208) 334-6626.